

Office Use Only
Patient Health Record #: _____
Appointment Date and Time: _____

### Cardiorespiratory Services Requisition

Patient Name: _____	Alternate Phone #: _____
Date of Birth (dd/mm/yyyy): _____	Health Card #: _____
Telephone #: _____	WSIB#: _____
<b>Patient will be notified by email, if email provided.</b> (Patient understands email may not allow secure communication)	Patient Email: _____

**Clinical Information** \_\_\_\_\_

\_\_\_\_\_

**Medication List (required):** \_\_\_\_\_

\_\_\_\_\_

### Pulmonary Function Testing

**Full PFT** (refer to protocol): (Hemoglobin required for Diffusion)  
 Pre/Post SABA (400mcg Ventolin) Spirometry, Volumes, Diffusion Hb \_\_\_\_, Airway Resistance, O<sub>2</sub> Saturation  
 (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)

**Spirometry Pre/Post SABA (400 mcg Ventolin):** (for screening and/or follow-up)  
 (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)

**Spirometry Only** (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers if available)

**Arterial Blood Gases:**

Room Air     
  For Home O<sub>2</sub>     
  On O<sub>2</sub> \_\_\_\_ L/m

**Oximetry**

At rest  
 With exercise (6 minutes brisk walking – may include stairs)  
 Overnight

### Cardiology Test

**Stress Testing (Stress Test Only - Internal Medicine consultation is not included if ordered on this form)**  
 Please include relevant clinical information above. Includes Exercise Oximetry. Running shoes and medication list required. Ladies should wear a bra and a loose fitting, short sleeved blouse or t-shirt.

**Ambulatory Blood Pressure Monitoring:**  
 Instructions: Please wear a loose short sleeved top. Test is not covered by OHIP. You will be invoiced. Bring a medication list.

**Electrocardiogram (ECG/EKG)**  
 Instructions: Please don't use oils/powders on chest/arms/legs prior to testing.

**Holter Monitor:**     24hour     48hour     14 days  
 Instructions: Please don't use oils/powders on chest/arms/legs prior to testing. Ladies should wear a bra and a loose fitting blouse or t-shirt. Please bring medication list.

**REFERRING PHYSICIAN:**

Practitioner's Name (Print) \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Billing No: \_\_\_\_\_

Copy to: \_\_\_\_\_ Date: \_\_\_\_\_  
(dd/mm/yyyy)